

FILED OCT 19 1944

Registration District No. 192

Primary Registration District No. 4205

Registrar's No. _____

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Anderson
(c) Name of hospital or institution: neither
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME THULIA SULLIVAN

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife John A. Sullivan 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased Dec 24 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 9 13 hr. min.

9. Birthplace Marionville Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation House

11. Industry or business ---

MOTHER FATHER
12. Name George Perry
13. Birthplace Unknown Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Alpha Black
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Harvey Mae Gough

(b) Address Anderson, Mo

17. (a) Burial (b) Date thereof 9-9-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Raytown, Ark

18. (a) Signature of funeral director E. P. Pickett

(b) Address Wilson St. Ark

19. (a) 10-13-44 (b) Virginia Buck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald
(c) City or town Anderson
(If outside city or town limits, write "RURAL")
(d) Street No. ---
(If rural, give location)
(e) If foreign born, how long in U. S. A. --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 7
year 1944 hour 6:35 minute PM M.

21. I hereby certify that I attended the deceased from 9/6/44 19, to 9/7/44 19, that I last saw her alive on 9/7/44 19, and that death occurred on the date and hour stated above.

Immediate cause of death Hæmorrhage, Gastric

Due to CYANURAZ 17 STARCH

Due to ---

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations H&B

Of autopsy ---

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. P. Pickett (M.D. or other) _____
Address Anderson Mo Date signed 9/7/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 1944-1045-

Date Filed OCT 16 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~only~~.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed E. P. Grant.....

Licensed Embalmer No. 437.....

P. O. Address Silsan Spgs. 1.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.